FOR OHF USE

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2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0045658

Facility Name: SANGAMON NURSING & REHAB CENTER

Address: 2800 WEST LAWRENCE (Number) SPRINGFIELD (City) 62704 (Zip Code)

County: SANGAMON

Telephone Number: (217) 787-1955 **Fax #** (217) 787-7926

IDPA ID Number: 37-1414168

Date of Initial License for Current Owners: 10/01/2001

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2005 to 12/31/2005 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) BEHJAMIN KLEIN
(Title) MANAGER

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA, PARTNER
(Firm Name & Address) KRUPNICK, BOKOR, KAGDA & BROOKS, LTD, 3750 W DEVON, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number SANGAMON NURSING & REHAB CENTER # 0045658 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	170	Intermediate (ICF)	170	62,050	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	170	TOTALS	170	62,050	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			6,083	6,083	8
9	SNF/PED					9
10	ICF	37,816	4,721		42,537	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	37,816	4,721	6,083	48,620	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.36%

D. How many bed-hold days during this year were paid by the Department?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 10/01/01

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 10/01/01 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 25 and days of care provided 5,914

Medicare Intermediary ADMINISTAR

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2005 Fiscal Year: 12/31/2005

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number SANGAMON NURSING & REHAB CENTE # 0045658 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	254,747	18,420	9,073	282,240		282,240		282,240			1
2	Food Purchase		236,608		236,608		236,608	(567)	236,041			2
3	Housekeeping	137,263	22,770		160,033		160,033		160,033			3
4	Laundry	82,391	20,693		103,084		103,084		103,084			4
5	Heat and Other Utilities			178,100	178,100		178,100	4,448	182,548			5
6	Maintenance	62,565	68,967	3,850	135,382		135,382	4,487	139,869			6
7	Other (specify):*			26,932	26,932		26,932		26,932			7
8	**TOTAL General Services**	536,966	367,458	217,955	1,122,379		1,122,379	8,368	1,130,747			8
	B. Health Care and Programs											
9	Medical Director			23,400	23,400		23,400		23,400			9
10	Nursing and Medical Records	1,960,200	137,280	9,363	2,106,843		2,106,843		2,106,843			10
10a	Therapy	41,725		55,656	97,381		97,381		97,381			10a
11	Activities	47,808	5,256		53,064		53,064		53,064			11
12	Social Services	47,326		1,254	48,580		48,580		48,580			12
13	CNA Training											13
14	Program Transportation			8,404	8,404		8,404		8,404			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,097,059	142,536	98,077	2,337,672		2,337,672		2,337,672			16
	C. General Administration											
17	Administrative	62,483		112,500	174,983		174,983	40,583	215,566			17
18	Directors Fees											18
19	Professional Services			66,092	66,092		66,092	758	66,850			19
20	Dues, Fees, Subscriptions & Promotions			41,757	41,757		41,757	(15,982)	25,775			20
21	Clerical & General Office Expenses	106,915	34,462	362,260	503,637		503,637	(235,057)	268,580			21
22	Employee Benefits & Payroll Taxes			542,486	542,486		542,486		542,486			22
23	Inservice Training & Education			2,880	2,880		2,880		2,880			23
24	Travel and Seminar			8,315	8,315		8,315	271	8,586			24
25	Other Admin. Staff Transportation							2,158	2,158			25
26	Insurance-Prop.Liab.Malpractice			110,715	110,715		110,715	781	111,496			26
27	Other (specify):*			60,000	60,000		60,000	(40,949)	19,051			27
28	**TOTAL General Administration**	169,398	34,462	1,307,005	1,510,865		1,510,865	(247,437)	1,263,428			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,803,423	544,456	1,623,037	4,970,916		4,970,916	(239,069)	4,731,847			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID#: SANGAMON NURSING & REHAB CENTER #0045658 **Report Period Beginning: 01/01/2005** **Ending: 12/31/2005**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	9,073	
	REPAIRS & MAINTENANCE		0	
			0	9,073
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		0	
			0	0
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		0	
	ELECTRICITY		129,342	
	WATER		48,758	
	CABLE TV - LOBBY		0	
			0	178,100
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		3,850	
	PAINTING & DECORATING		0	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		0	
	ELEVATOR MAINTENANCE & REPAIR		0	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		0	
	FIRE SERVICE		0	
			0	
			0	
			0	3,850
7	**OTHER**			
	SCAVENGER		26,932	
	SECURITY SERVICE		0	26,932
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	23,400	23,400

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2		
	LABORATORY & XRAY EXPENSE		0	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	956	
	PHARMACY CONSULTANT	XVIII B 39-2	8,407	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	0	
			0	
			0	9,363
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES			
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	27,603	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	22,729	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	5,324	55,656
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	0	
			0	0
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	1,254	
			0	1,254
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number SANGAMON NURSING & REHAB CENTER #0045658 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		8,404	8,404
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	112,500	112,500
18	**DIRECTORS FEES**		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	21,188	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	44,904	
			0	66,092
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	13,753	
	EMPLOYEE WANT ADS	XIX F	5,717	
	CONTRIBUTIONS	VI 20 XIX F	750	
	DUES & SUBSCRIPTIONS	XIX F	17,239	
	LICENSES & PERMITS	XIX F	867	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	0	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	2,565	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	866	41,757
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		6,070	
	EQUIPMENT REPAIR & MAINTENANCE		9,351	
	OUTSIDE CLERICAL SERVICES		0	
	PENALTIES / OVERDRAFT CHARGES	VI 18	0	
	HOME OFFICE EXPENSE		302,500	
	THEFT & DAMAGE LOSS		7,751	
	TELEPHONE		36,588	
	MESSENGER SERVICE		0	
			0	362,260

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	212,853	
	UNEMPLOYMENT COMPENSATION	XIX D	170,049	
	WORKERS COMPENSATION INSURANCI	XIX D	117,167	
	HOSPITALIZATION INSURANCE	XIX D	32,436	
	EMPLOYEE BENEFITS - OTHER	XIX D	6,036	
	EMPLOYEE PHYSICAL EXAMS	XIX D	3,945	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	0	
	CHICAGO HEAD TAX	XIX D	0	542,486
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		2,880	2,880
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	8,315	
			0	
			0	8,315
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		0	0
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		110,715	110,715
27	**OTHER**			
	BAD DEBTS	VI 24	60,000	
				60,000

GRAND TOTAL COLUMN 3 OTHER 1,623,037

SANGAMON NURSING & REHAB CENTER
EMPLOYEE MEAL RECLASSIFICATION (PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22)
12/31/2005

TOTAL FOOD PURCHASE	236,608	PATIENT MEALS	145860
LESS SALES TAX	(567)	ADD EMPLOYEE MEALS	0
NET FOOD	236,041	TOTAL MEALS/YEAR	145860
TOTAL PATIENT CENSUS	48,620	NET FOOD	236041
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	145860
TOTAL PATIENT MEALS	145860	COST PER MEAL	1.62
		TIME EMPLOYEE MEALS	0
ADD # EMPLOYEE MEALS/DAY	0		
TIME # DAYS	365	EMPLOYEE MEAL RECLASSIFICATION	0
TOTAL EMPLOYEE MEALS	0		

Facility Name & ID Number SANGAMON NURSING & REHAB CENTER #0045658 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			20,858	20,858		20,858	4,859	25,717			30
31	Amortization of Pre-Op. & Org.			5,600	5,600		5,600	536	6,136			31
32	Interest			94,402	94,402		94,402	13,875	108,277			32
33	Real Estate Taxes			72,194	72,194		72,194	5,965	78,159			33
34	Rent-Facility & Grounds			531,303	531,303		531,303	10,548	541,851			34
35	Rent-Equipment & Vehicles			67,771	67,771		67,771		67,771			35
36	Other (specify):*											36
37	**TOTAL Ownership**			792,128	792,128		792,128	35,783	827,911			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		182,288	272,661	454,949		454,949		454,949			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			93,075	93,075		93,075		93,075			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		182,288	365,736	548,024		548,024		548,024			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,803,423	726,744	2,780,901	6,311,068		6,311,068	(203,286)	6,107,782			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number SANGAMON NURSING & REHAB CENTER # 0045658 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(13,494)	30		9
10	Interest and Other Investment Income	(287)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(567)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties		21		18
19	Entertainment		20		19
20	Contributions	(3,315)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers	(2,756)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(60,000)	27		24
25	Fund Raising, Advertising and Promotional	(13,753)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (94,172)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(109,114)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (109,114)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (203,286)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SANGAMON NURSING & REHAB CENTER

ID# 0045658

Report Period Beginning: 01/01/2005

Ending: 12/31/2005

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$ 0	6	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number SANGAMON NURSING & REHAB CENTER # 0045658 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(567)	0	0	0	0	0	0	0	0	0	0	(567)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	4,448	0	0	0	0	0	0	0	0	4,448	5
6	Maintenance	0	0	4,487	0	0	0	0	0	0	0	0	4,487	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(567)	0	8,935	0	0	0	0	0	0	0	0	8,368	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	40,583	0	0	0	0	0	0	0	0	40,583	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(2,756)	0	3,514	0	0	0	0	0	0	0	0	758	19
20	Fees, Subscriptions & Promotions	(17,068)	0	1,086	0	0	0	0	0	0	0	0	(15,982)	20
21	Clerical & General Office Expenses	0	(302,500)	67,410	33	0	0	0	0	0	0	0	(235,057)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	271	0	0	0	0	0	0	0	0	271	24
25	Other Admin. Staff Transportation	0	0	2,158	0	0	0	0	0	0	0	0	2,158	25
26	Insurance-Prop.Liab.Malpractice	0	0	781	0	0	0	0	0	0	0	0	781	26
27	Other (specify):*	(60,000)	0	19,051	0	0	0	0	0	0	0	0	(40,949)	27
28	**TOTAL General Administration**	(79,824)	(302,500)	134,854	33	0	0	0	0	0	0	0	(247,437)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(80,391)	(302,500)	143,789	33	0	0	0	0	0	0	0	(239,069)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number SANGAMON NURSING & REHAB CENTER # 0045658 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(13,494)	0	1,146	17,207	0	0	0	0	0	0	0	4,859	30
31	Amortization of Pre-Op. & Org.	0	0	0	536	0	0	0	0	0	0	0	536	31
32	Interest	(287)	0	0	14,162	0	0	0	0	0	0	0	13,875	32
33	Real Estate Taxes	0	0	0	5,965	0	0	0	0	0	0	0	5,965	33
34	Rent-Facility & Grounds	0	0	10,548	0	0	0	0	0	0	0	0	10,548	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(13,781)	0	11,694	37,870	0	0	0	0	0	0	0	35,783	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(94,172)	(302,500)	155,483	37,903	0	0	0	0	0	0	0	(203,286)	45

Facility Name & ID Number SANGAMON NURSING & REHAB CENTER # 0045658 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SCHEDULE ATTACHED		SCHEDULE ATTACHED		SCHEDULE ATTACHED		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	21	HOME OFFICE FEES	$ 302,500	PLATINUM HEALTH CARE LLC	100.00%	$	$ (302,500)	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 302,500			$	$ * (302,500)	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number SANGAMON NURSING & REHAB CENTER # 0045658 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	PLATINUM HEALTH CARE	100.00%	$ 4,448	$ 4,448	15
16	V	6	REPAIR & MAINTENANCE		" " "		4,487	4,487	16
17	V	17	ADMINISTATIVE SALARY		" " "		40,583	40,583	17
18	V	19	PROFESSIONAL FEES		" " "		3,514	3,514	18
19	V	20	FEES & SUBSCRIPTIONS		" " "		1,086	1,086	19
20	V	21	OFFICE EXPENSE		" " "		67,410	67,410	20
21	V	24	EDUCATION & SEMINARS		" " "		271	271	21
22	V	25	TRAVEL		" " "		2,158	2,158	22
23	V	27	EMPLOYEE BENEFITS		" " "		19,051	19,051	23
24	V	26	INSURANCE		" " "		781	781	24
25	V	30	DEPRECIATION		" " "		1,146	1,146	25
26	V	34	OFFICE RENT		" " "		10,548	10,548	26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 155,483	$ * 155,483	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SANGAMON NURSING & REHAB CENTER # 0045658 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	21	OFFICE EXPENSE	$	PHLG LLC	100.00%	$ 33	$ 33	15
16	V	31	AMORTIZATION				536	536	16
17	V	30	DEPRECIATION				17,207	17,207	17
18	V	32	INTEREST				14,162	14,162	18
19	V	33	REAL ESTATE TAXES				5,965	5,965	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 37,903	$ * 37,903	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SANGAMON NURSING & REHAB CENTI # 0045658 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week: Hours	Percent	Compensation Included in Costs for this Reporting Period**: Description	Amount	Schedule V. Line & Column Reference	
1	MARK SHAPIRO	ADMINISTRATIVE	SCHEDULE ATTACHED					MGMT FEE	$ 37,500	17-3	1
2	BRIAN LEVINSON	ADMINISTRATIVE						MGMT FEE	37,500	17-3	2
3	BEN KLEIN	ADMINISTRATIVE						MGMT FEE	37,500	17-3	3
4	BEN KLEIN	ADMINISTRATIVE						SALARY	40,583	17-7	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 153,083		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number SANGAMON NURSING & REHAB CENTER # 0045658 Report Period Beginning: 01/01/2005 Ending: 2/31/2005

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: PLATINUM HEALTHCARE LLC
Street Address: 7444 LONG AVENUE
City / State / Zip Code: SKOKIE, IL 60077
Phone Number: (847) 329-4100
Fax Number: (847) 329-4900

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	TOTAL PATIENT DAYS	415,423	11	$ 38,007	$	48,620	$ 4,448	1
2	6	REPAIR & MAINTENANCE	" " "	415,423	11	38,341		48,620	4,487	2
3	17	ADMINISTATIVE SALARY	" " "	415,423	11	346,750	346,750	48,620	40,583	3
4	19	PROFESSIONAL FEES	" " "	415,423	11	30,027		48,620	3,514	4
5	20	FEES & SUBSCRIPTIONS	" " "	415,423	11	9,282		48,620	1,086	5
6	21	OFFICE EXPENSE	" " "	415,423	11	575,967	429,868	48,620	67,410	6
7	24	EDUCATION & SEMINARS	" " "	415,423	11	2,319		48,620	271	7
8	25	TRAVEL	" " "	415,423	11	18,439		48,620	2,158	8
9	27	EMPLOYEE BENEFITS	" " "	415,423	11	162,778		48,620	19,051	9
10	26	INSURANCE	" " "	415,423	11	6,673		48,620	781	10
11	30	DEPRECIATION	" " "	415,423	11	9,790		48,620	1,146	11
12	34	OFFICE RENT	" " "	415,423	11	90,129		48,620	10,548	12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,328,502	$ 776,618		$ 155,483	25

Facility Name & ID Number SANGAMON NURSING & REHAB CENTER # 0045658 Report Period Beginning: 01/01/2005 Ending: 2/31/2005

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: PHLG LLC
Street Address: 7444 LONG AVENUE
City / State / Zip Code: SKOKIE, IL 60077
Phone Number: (847) 329-4100
Fax Number: (847) 329-4900

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	21	OFFICE EXPENSE	TOTAL PATIENT DAYS	415,423	11	$ 285	$	48,620	$ 33	1
2	31	AMORTIZATION	" " "	415,423	11	4,583		48,620	536	2
3	30	DEPRECIATION	" " "	415,423	11	147,023		48,620	17,207	3
4	32	INTEREST	" " "	415,423	11	121,002		48,620	14,162	4
5	33	REAL ESTATE TAXES	" " "	415,423	11	50,966		48,620	5,965	5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 323,859	$		$ 37,903	25

Facility Name & ID Number SANGAMON NURSING & REHAB CENTE # 0045658 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	MB FINANCIAL		X	WORKING CAPITAL	INTEREST	10/31/01	1,600,000	1,600,000		7.2500	94,402	6
7												7
8	RELATED PARTY	X									14,162	8
9	TOTAL Facility Related						$ 1,600,000	$ 1,600,000			$ 108,564	9
	B. Non-Facility Related*											
10	IRS, IDR, ETC		X	LATE FEES								10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 1,600,000	$ 1,600,000			$ 108,564	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number SANGAMON NURSING & REHAB CENTER **#** 0045658 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2004 report.	$	67,200	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	69,794	2
3. Under or (over) accrual (line 2 minus line 1).	$	2,594	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)	$	69,600	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	72,194	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2000		8
2001		9
2002	48,429	10
2003	66,493	11
2004	69,794	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2004 TAX BILL.

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2004	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME SANGAMON NURSING & REHAB CENTER COUNTY SANGAMON

FACILITY IDPH LICENSE NUMBER 0045658

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	14-31.0-100-017	NURSING HOME	$ 69,794.34	$ 69,794.34
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 69,794.34	$ 69,794.34

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number SANGAMON NURSING & REHAB CENTER # 0045658 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: _____ B. General Construction Type: Exterior _____ Frame _____ Number of Stories _____

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 27,999
2. Number of Years Over Which it is Being Amortized: 5
3. Current Period Amortization: 5,600
4. Dates Incurred: 10/01

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number SANGAMON NURSING & REHAB CENTER # 0045658 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8					133,751	3,258		3,258			8
	Improvement Type**										
9	LIGHT FIXTURES			2002	926	34	27.5	34		117	9
10	HVAC COMPRESSORS			2002	1,058	38	27.5	38		138	10
11	CARPET FLOORING			2002	2,142	78	27.5	78		276	11
12	ROOFING, PAINTING			2003	4,700	170	27.5	170		423	12
13	DRIVEWAY REPAIR			2003	3,819	255	15	255		606	13
14	CARPETING, WALLPAPERING			2003	12,558	1,419	5	1,419		4,699	14
15	AC/COMPRESSOR			2003	3,316	121	27.5	121		292	15
16	TILES, PAINTING, BLINDS, DOORS			2004	18,257	664	27.5	664		971	16
17	FIRE SYSTEM, COMPRESSOR			2004	3,030	110	27.5	110		158	17
18	TILE, WALLPAPER, DOOR			2005	6,449	228	27.5	228		228	18
19	FIRE ALARM REPAIR, AC			2005	13,663	107	27.5	107		107	19
20	SIDEWALK, CATCH BASIN REPAIR			2005	5,613	187	27.5	187		187	20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number SANGAMON NURSING & REHAB CENTER # 0045658 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 209,282	$ 6,669		$ 6,669	$	$ 8,202	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SANGAMON NURSING & REHAB CENTER # 0045658 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 113,327	$ 12,770	$ 11,333	$ (1,437)	10	$ 25,461	71
72	Current Year Purchases	23,842	4,677	2,384	(2,293)	10	2,384	72
73	Fully Depreciated Assets							73
74	RELATED PARTY	52,719	15,036	5,272	(9,764)			74
75	TOTALS	$ 189,888	$ 32,483	$ 18,989	$ (13,494)		$ 27,845	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 399,170	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 39,152	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 25,658	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (13,494)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 36,047	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number SANGAMON NURSING & REHAB CENTER # 0045658 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: SPRINGFIELD MANOR
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		170		$ 531,303			3
4	Additions							4
5								5
6								6
7	TOTAL		170		$ 531,303 **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	9/2006	$
13.	9/2007	$
14.	9/2008	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ 67,112 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$ 659.00	$ 659	17
18					18
19					19
20					20
21	TOTAL		$ 659.00	$ 659	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number SANGAMON NURSING & REHAB CENTER # 0045658 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

   THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number SANGAMON NURSING & REHAB CENTER # 0045658 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	$		$ 94,055	$		$ 94,055	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			56,692			56,692	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39.3	hrs			121,914			121,914	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				157,651		157,651	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): LAB.RADIOLOGY	39-2					24,637		24,637	13
14	TOTAL			$		$ 272,661	$ 182,288		$ 454,949	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number SANGAMON NURSING & REHAB CENTER # 0045658 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2005 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (247,096))	1,344,484		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	282,332		6
7	Other Prepaid Expenses	4,823		7
8	Accounts Receivable (owners or related parties)	11,017		8
9	Other(specify): R.E..ESCROW DEP.	76,119		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,718,775	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	75,531		15
16	Equipment, at Historical Cost	137,168		16
17	Accumulated Depreciation (book methods)	(115,353)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	27,999		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(23,799)		20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 101,546	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,820,321	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,367,864	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,978,395		29
30	Accrued Salaries Payable	124,600		30
31	Accrued Taxes Payable (excluding real estate taxes)	27,823		31
32	Accrued Real Estate Taxes(Sch.IX-B)	69,600		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,568,282	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,568,282	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,747,961)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,820,321	$	48

***(See instructions.)**

Facility Name & ID Number SANGAMON NURSING & REHAB CENTER # 0045658 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,580,366)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,580,366)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(167,595)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (167,595)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (1,747,961)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number SANGAMON NURSING & REHAB CENTER # 0045658 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,982,592	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,982,592	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	151,764	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 151,764	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	287	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 287	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	VENDING COMMISSIONS NET OF COST	2,830	28
28a	PARKING LOT REVENUE	6,000	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 8,830	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,143,473	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,122,379	31
32	Health Care	2,337,672	32
33	General Administration	1,510,865	33
	B. Capital Expense		
34	Ownership	792,128	34
	C. Ancillary Expense		
35	Special Cost Centers	454,949	35
36	Provider Participation Fee	93,075	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,311,068	40
41	**Income before Income Taxes (line 30 minus line 40)****	(167,595)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (167,595)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** NO **If not, please attach a reconciliation.**
TAX RETURN PREPARED ON CASH BASIS

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number SANGAMON NURSING & REHAB CENTER # 0045658 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,041	2,154	$ 68,964	$ 32.02	1
2	Assistant Director of Nursing	3,316	3,397	79,899	23.52	2
3	Registered Nurses	7,764	8,054	174,873	21.71	3
4	Licensed Practical Nurses	34,509	36,685	576,018	15.70	4
5	CNAs & Orderlies	83,457	87,388	977,537	11.19	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,836	2,008	41,725	20.78	8
9	Activity Director	1,912	1,950	21,287	10.92	9
10	Activity Assistants	3,226	3,415	26,521	7.77	10
11	Social Service Workers	3,239	3,407	47,326	13.89	11
12	Dietician					12
13	Food Service Supervisor	1,830	1,950	27,800	14.26	13
14	Head Cook	27,552	28,364	226,947	8.00	14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	4,097	4,412	62,565	14.18	17
18	Housekeepers	13,977	14,711	137,263	9.33	18
19	Laundry	9,269	10,103	82,391	8.16	19
20	Administrator	1,366	1,424	62,483	43.88	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,895	7,278	106,915	14.69	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,355	1,429	20,781	14.54	31
32	Other Health Care(specify)					32
33	Other(specify) CARE PLAN	4,064	4,288	62,128	14.49	33
34	TOTAL (lines 1 - 33)	211,705	222,417	$ 2,803,423 *	$ 12.60	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$ 9,073	1-3	35
36	Medical Director		23,400	9-3	36
37	Medical Records Consultant		956	10-3	37
38	Nurse Consultant		0	10-3	38
39	Pharmacist Consultant		8,407	10-3	39
40	Physical Therapy Consultant		27,603	10a-3	40
41	Occupational Therapy Consultant		22,729	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant		5,324	10a-3	43
44	Activity Consultant		0	11-3	44
45	Social Service Consultant		1,254	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 98,746		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$ 0	10-3	50
51	Licensed Practical Nurses		0	10-3	51
52	Certified Nurse Assistants/Aides		0	10-3	52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number SANGAMON NURSING & REHAB CENTER # 0045658 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
JEFFREY ADAMS	ADMIN		$ 46,339
GLENN MILLER	ADMIN		1,054
THOMAS MULLINS	ADMIN		15,090
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 62,483

B. Administrative - Other

Description	Amount
MANAGEMENT FEES	$ 112,500
TOTAL (agree to Schedule V, line 17, col. 3)	$ 112,500
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		$
SEE SCHEDULE ATTACHED		66,092
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 66,092

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 117,167
Unemployment Compensation Insurance	170,049
FICA Taxes	212,853
Employee Health Insurance	32,436
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	6,036
EMPLOYEE PHYSICAL EXAMS	3,945
TOTAL (agree to Schedule V, line 22, col.8)	$ 542,486

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	5,717
Health Care Worker Background Check	866
(Indicate # of checks performed)	
MARKETING/ADV/PROMO	13,753
TRUST/FRANCHISE/CONTRIB/ETC	3,315
LICENSES & PERMITS	867
DUES & SUBSCRIPTIONS	17,239
MGMT CO ALLOCATION	1,086
TRUST/FRANCHISE/CONTRIB/ETC	(3,315)
Less: Public Relations Expense	(0)
Non-allowable advertising	(13,753)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 25,775

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	8,315
Seminar Expense	
MGMT CO ALLOCATION	271
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 8,586

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number SANGAMON NURSING & REHAB CENTER # 0045658 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1	PAINT/DECORATING		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number SANGAMON NURSING & REHAB CENTER # 0045658 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union?

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **IL HCA-$8135 & ICLTC-$-8721**

(3) Did the nursing home make political contributions or payments to a politica
action organization? **YES** If YES, have these costs
been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the
end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures
consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions fo
Schedule VII)? YES NO If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Departmen
during this cost report period. $ **93,075**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V
for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed tc
the Department, in addition to the daily rate, been properly classifiec
in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services fo
the patient census listed on page 2, Section B? **NO** For example,
is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach
a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits
on Schedule V. $ **0** Has any meal income been offset against
related costs? Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation fo
residents? **NO** If YES, please indicate the amount of income earned from such a
program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all othe
times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted
out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the
cost report require that a copy of this audit be included with the cost report. Has this copy
been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out
out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services
performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees